

DATE: **DRAFT**__

CRITERIA FOR PRIOR AUTHORIZATION

Appropriate NDC Code
(Item or Procedure Here)

Opioid dependence agents
(Item or Procedure Here)

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drug(s) requires prior authorization:
Buprenorphine/Naloxone(Suboxone®) and Buprenorphine (Subutex®)

CRITERIA: (must meet all of the following)

1. Patient must be receiving opioid dependence treatment for withdrawal. Sustaining the addiction will not be approved.
2. Qualified prescribing physician (under Drug Addiction Treatment Act of 2000) must provide confirmation of their waiver from SAMHSA.
3. Prescribing provider must practice in Kansas and be a Kansas Medicaid Provider.
4. Beneficiary will be place in lock-in.

Drug Utilization Review Committee Director

Date _____

Pharmacy Program Manager,
Division of Health Policy and Finance

Date _____